
The Diversity of Case Management Needs for the Care of Homeless Persons

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Synopsis

Health care providers have been attempting to meet the special needs of homeless people on a national level

since 1984. The need to implement strategies specific to serving the diversity of services required by homeless people has been apparent. To devise appropriate strategies, clinical information was drawn from the Health Resources and Services Administration-Health Care for the Homeless (HRSA-HCH) projects, which were created in 1987 primarily to fill such a need. In addition, data gathered by the HCH projects (1984-87) funded by the Robert Wood Johnson and Pew Memorial Trust were used. It is suggested that the past mode of providing health care for the homeless has been found to be inadequate when confronting the complex problems of the homeless person of today.

In general, health care providers need to focus more on case management activities, which may include activities not necessarily associated with the provision of health care services (for example, finding and providing food, clothing, shelter, and assessing entitlement eligibility) to achieve the ultimate goal—stabilization—and when possible, reintegration of the homeless person back into society.

THE HOMELESS are a heterogeneous group of people. Although in the past they may have been associated exclusively with the alcohol and substance abuse subculture, today a new type of homeless person is emerging. Thus, although the previous methods of treating the health care, psychosocial, and economic needs of these persons may have been effective, independent of one another, today a new comprehensive strategy must be implemented. This strategy must be flexible and tailored to the homeless person's needs.

The Stewart B. McKinney Homeless Assistance Act of 1987 provided \$75 million during calendar years 1988-89 to provide health care to homeless people. As a result of the influx of funds, in 1987 the Health Care for the Homeless (HCH) Program of the Health Resources Services Administration (HRSA) was created.

The HRSA-HCH Program was modeled after the HCH Program funded by the Robert Wood Johnson and Pew Memorial Trust (RWJ), which funded health care for the homeless projects in 19 major metropolitan areas from August 1984 through November 1987. Under this earlier program, outpatient health services, including primary care, substance abuse treatment, and mental health, and case management services were provided.

This paper presents a discussion of the diversity of the homeless population, using HRSA-HCH calendar years (CY) 1988 and 1989 data in relation to the type of

case management activities the homeless might require to restore them eventually to the mainstream of society.

Demographics

As defined, the homeless population is a group of people whose common thread includes, but may not be limited to, people for whom permanent housing is unavailable, including persons whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations. As such, the homeless population includes families with children, mentally ill persons, substance abusers, runaway youth, and people with acquired immunodeficiency syndrome (AIDS). Given the diversity of this population, it is natural to assume that their needs would be different and, thus, the intensity of care would be different.

As a group, the homeless are at high risk for many minor health care problems, which if not treated, could potentially develop into life-threatening illnesses (1-4). In addition, many resources were available for the homeless people, that is, food, clothing, and shelter. However, there was a paucity of organizations that acted on the behalf of homeless people, either to provide health care services or to channel them to the appropriate sources for nonmedical care.

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In response, on July 22, 1987, President Reagan signed the Stewart B. McKinney Homeless Assistance Act of 1987. The act is designed to provide a wide array of Federal help to communities through organizing and providing a comprehensive package of services to homeless people. During December of 1987, HRSA awarded 109 HCH grants to 43 States, Puerto Rico, and the District of Columbia for the provision of comprehensive health care services to homeless people. Awards ranged from \$62,000 to \$2 million, and most projects began serving patients in March 1988. In 1989, projects received approximately \$45 million and an additional \$31.5 million in 1990 to serve people from January through September.

Although not all projects' staff responded to all questions, the following represents service data derived from the first 2 years of operation of the HRSA projects:

Category	CY 1988	CY 1989
Total persons served	231,000	352,000
Total visits	783,000	1,356,000

The demographic profile of the homeless, derived from CY 1989 data, is

- 36 percent were black,
- 47 percent were white,
- 11 percent were Hispanic,
- 16 percent were in some other category,
- 20 percent or 72,000 were women ages 15–44; of these 5,998 were pregnant, and 27 percent of those were teenagers,
- 21 percent were children and their parent(s) living as a family unit or were homeless runaway youths.

Following the RWJ model, HRSA–HCH projects were designed to meet the health care needs of homeless people where they congregate. Thus, HCH providers sought out homeless people in settings where they gathered. The following CY 1988 data show their housing status:

- 38 percent were residents of emergency shelters,
- 13 percent were living on the street,
- 6 percent were living in transitional housing, and
- 8 percent were doubled up, that is, persons or fam-

ilies living with friends or relatives in other than a permanent arrangement.

Health Problems of the Homeless

Based on CY 1988–89 data, the following is a breakdown of the services received:

Service	Persons seen in 1988	1988 visits	1989 visits ¹
Primary care	315,000	101,000	592,000
Mental health.	8,000	55,000	103,000
Substance abuse	15,000	60,000	210,000
Case management	38,000	202,000	343,000

¹Data for persons seen in 1989 have yet to be compiled.

The data from the RWJ projects have been used to estimate the leading health problems of the homeless.

- 38 percent suffer from alcohol abuse (47 percent of the men, 16 percent of the women),
- 33 percent suffer from mental illness (MI); however, women have twice the rate of MI disorder than men,
- less than 10 percent are chronically mentally ill (2).

The most common physical health problems encountered in the RWJ–HCH projects were acute episodic disorders, including upper respiratory infections, traumas (injuries), and skin ailments, in that order. The principal chronic or major disorders, also in order of frequency, have been hypertension, gastrointestinal ailments, peripheral vascular disease, problems with dentition, neurological disorders, eye disorders, cardiac disease, genitourinary problems, musculoskeletal ailments, ear disorders, and chronic obstructive pulmonary disease (2, 3). Overall, it is estimated that 41 percent of the RWJ–HCH clients are afflicted with some chronic physical disorder, compared with 25 percent of the U.S. ambulatory patient population in general (2).

In addition, approximately one client in six is afflicted with some infectious or communicable disorder that represents a potential risk to the public's health. Most of these are minor conditions—skin ailments, lice infestations. Still, serious respiratory infections (that is, pneumonia and pleurisy) are observed among more than 3 percent; sexually transmitted venereal infections, about 2 percent; and active tuberculosis, approximately 0.5 percent (2).

According to CY 1988 HRSA–HCH data, the leading diagnoses among patients ages 15 or older were alcohol and other substance abuse, skin disorders, mental illness, hypertension, pulmonary disease, and trauma (5).

Similar findings were reported by Nyamathi and Shuler in a 1989 study of urban homeless adults in Los Angeles (6). According to this study, the top five medi-

cal problems reported by the homeless included upper respiratory infections, rashes, sores, or swelling of the extremities, hypertension, and injuries.

Homeless Families and Children

The image of homeless people as ravaged by chronic mental illness, alcoholism, and drugs has been a popular characterization of this population. However true this may have been in the past, the demographics indicate that a different image of a homeless person is emerging. A 1985 survey of 26 major cities conducted by the U.S. Conference of Mayors showed a 33 percent increase in the number of families with children seeking shelter services (7), and the 1988 National Survey of Shelters for the Homeless found that families make up two of every five homeless persons that use the shelters (8).

CY 1988 HRSA-HCH providers reported the six most common diagnoses for homeless children ages 0-14 as follows: anemia, undernutrition, incomplete immunizations, skin disorders, pulmonary disease, and developmental delay (5).

Many of these families have entered the ranks of the homeless because of economic problems ranging from loss of employment to the lack of availability of affordable, low-cost housing (1, 9). Most are made up of single women and children as opposed to single males accompanied by children. As a group, their health problems differ from those of single males. For example, mothers are afflicted by psychological distress resulting from the unstable housing situation, from the situation from which they have come, and increased incidence of low birth weight and mortality of their infants. The children suffer from malnutrition, lack of immunizations, and increased prevalence of chronic physical disorders (2, 10). The incidence of acute disease and prevalence of chronic disease among this group may depend on the duration of their homelessness.

Homeless Mentally Ill and Substance Abusers

The chronically mentally ill (CMI) person and the substance abuser (alcohol and drug) become homeless, in some instances, as a result of some of the same reasons as do families (2, 9). However, the CMI and substance abuser require more than an economic intervention to resolve the condition for which they are afflicted. And, should they be dually diagnosed, their need for services intensifies to an even greater degree (11).

The CMI and substance abuser most often require an array of services ranging in some cases from supervised living environments to education and job training, as

well as psychosocial rehabilitation (12). The application of treatment regimens for CMI and substance abusers should be contained in a treatment plan that outlines the incremental steps in assisting the homeless in obtaining the highest level of functioning possible. The overall monitoring of the patient's progress should be the responsibility of a case manager who provides health care as well as coordination of auxiliary services (that is, training, education, job) for the patient (13).

AIDS and Homelessness

The past 2 years have seen substantial improvements in the diagnosis and treatment of opportunistic infections and certain other manifestations of human immunodeficiency virus (HIV) infected patients, according to reports given at a recent conference on AIDS (14). This has meant that the quality and duration of life for infected persons has improved. However, homeless people who are HIV positive may not have as optimistic a prognosis due to environmental and physical deprivation resulting from their homeless status. This problem may become more prevalent as the number of intravenous (IV) drug abusers with HIV infection increases.

There is a high probability that the number of HIV positive homeless people will increase as the infection spreads in the population of IV drug abusers. The unstable living arrangements of this group will be further threatened by the onset of HIV infection.

Runaway Youth

For thousands of adolescents, home is any place that they can sleep for the night. In many metropolitan areas, these young people are the fastest growing segment of the homeless populations. Their stories are as unique as they are, yet a common bond holds them together—some have been sexually abused and have chosen to end it by leaving home. Others are discipline problems, and still others are substance abusers who select the street over parental control. They all seek to escape victimization by fleeing from their environment; the irony is that they are again victims on the streets. If not victims, they must victimize others.

The rate of pregnancy among homeless females can be looked to as a prime example of their victimization. The highest rate is approximately 25 percent and occurs for the cohort 16-19-year-olds; in the next oldest cohort, 20-24-year-olds, the rate exceeds 20 percent. This demonstrates a rate of pregnancies of about two times that of the national rate (15). Late or no prenatal care and little social support contribute to the high rate of low birth weight and infant mortality seen in this population (16).

The Juvenile Justice and Delinquency Prevention Act, Public Law 93-415, provides funding for 311 runaway shelters. These shelters are managed by the Family and Youth Services Bureau in the Department of Health and Human Services. The shelters have an advocate in the National Network of Runaway Youth Services, a nonprofit foundation, based in Washington, DC, and seek to provide food, lodging, and other social services to homeless youth.

The HRSA-HCH and the Family and Youth Services Bureau work together to provide primary care to this population through the 109 medical projects funded under the McKinney Act. According to CY 1989 data, approximately 21 percent of persons seen in HCH facilities were homeless families, including runaway youth.

In cities where there are common project sites, efforts are being made to coordinate the provision of services. The range of services will span the range of needs. Optimally, shelters for runaways should provide access to primary care services and material on communicable diseases, substance abuse information for runaway youth, and related training for shelter staff. Formal linkages have been formed between agencies, but more importantly, homeless youths will benefit—for example, increased access to primary and preventive health services, including prenatal care.

Case Management, Coordination of Care

The implementation of a case management system in programs providing health care services to homeless people is essential, given the environmental and psychosocial deficits often found in this population (1, 17). A case management system should be operational to assure both internal as well as external coordination of services and to provide followup and monitoring of the patient's progress (1, 18, 19).

As such an important facet of care, case management activities were funded under the HRSA-HCH Program. CY 1988 case management activities provided a ratio of 5 visits per person at approximately 202,000 visits per 38,000 persons. Preliminary CY 1989 data reveals a 59 percent increase in visits over 1988. (The 1989 data for persons has yet to be compiled.)

There are certain basic elements that compose a case management system: (a) definition of the role and responsibilities of the case manager, such as patient advocate, should be defined in terms of functions; (b) the case manager should have access to all of the providers involved in the treatment of the patient; and (c) the case manager should function as the "overseer" of the entire case from a system point of view, and as such needs to have more than a passing familiarity with the treatment plan developed for the patient. Because of

the complexity of the health and psychosocial problems faced by homeless people, it is important for the case manager to have a multidisciplinary approach and to "broker" the system on behalf of the patient (17, 18, 20, 21).

Conclusion

Given the diversity of this population, it is highly desirable that each local program be tailored to the needs of the population found within that project's service area. An integrated approach to addressing not only the health but the psychosocial and economic needs of the homeless population is critical; they cannot be separated.

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Report on a Seminar on Financing and Service Delivery Issues in Caring for the Medically Underserved

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Synopsis

Current national activities directed toward improving access to health care and assessing the potential effectiveness of various financing and service delivery strategies were reviewed by an invited group of 39 public and private sector health policy experts. Health care access problems of the medically underserved population were defined and a range of strategies for addressing them were presented. The seminar was held at Columbia, MD, July 6-7, 1988, sponsored jointly by the Robert Wood Johnson Foundation and the Health Resources and Services Administration, PHS.

SEMINAR PARTICIPANTS EXAMINING THE HEALTH care needs of medically unserved and underserved populations, and the respective roles of the public and private sectors in developing solutions, agreed that financing strategies alone cannot solve the problems. Service delivery strategies must be devised to ensure access to health care for people who have trouble accessing health care systems or who live in medically underserved locations, participants urged.

Health policy experts from the public and private sectors reviewed current activities aimed at improving access to health care. The 39 invited participants assessed the potential effectiveness of various financing and service delivery strategies and the respective roles of the public and private sectors in developing solutions.

The invitational seminar, "Public and Private Partnerships in Caring for the Medically Underserved," sponsored by the Robert Wood Johnson Foundation and the Public Health Service's Health Resources and Services Administration (HRSA), was held July 6-7, 1988, at Columbia, MD.

Throughout the seminar, participants stressed that access is a problem for the insured as well as the unin-

sured. While financing solutions are an essential component of any overall strategy, it is equally important to consider changes in the service delivery system to improve access for persons such as those who live in medically underserved locations.

The three phases of the evolution of the access issue as a national concern were summarized by Lawrence Lewin, of Lewin/ICF, Washington, DC. In the first stage, which started in the 1970s, policy discussion centered around concerns about hospitals' uncompensated care costs. The issue was not only the level of uncompensated care, but also the unequal distribution of that burden.

In the next stage, the focus of concern shifted to the uninsured population. The perception was that we could deal with the problem of health care for the indigent by simply finding a way to provide coverage to the uninsured. As policy analysts studied this problem, they were surprised to find that about 70 percent of the uninsured population were employed or in the family of an employed person.

Today, the issue of care for the indigent has evolved into a concern over access. The question is not simply how we provide insurance for the indigent, but how we